Kenneth Minkoff, MD
12 Jefferson Drive
Acton, MA 01720
781-932-8792x311
Kminkov@aol.com

STATE OF ARIZONA

SERVICE PLANNING GUIDELINES

CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS

(edited version)

November, 2000

SERVICE PLANNING GUIDELINES
CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS

I. Target Group: Any psychiatric disorder (including both Axis I and Axis II disorders, as well as substance-induced psychiatric disorders), combined with substance dependence and/or abuse.
N.B. For individuals with SMI, any persistent pattern of substance use may be defined as abuse.

II. Desired Outcome

A. Overview

Outcome for individuals with co-occurring disorders needs to be individualized, in accordance with a range of variables that specify treatment interventions and programs for particular subpopulations (see below). These variables include:

i. Subtype of co-occurring disorder
    1. Serious mental illness (SMI) + substance dependence
    2. SMI + substance abuse
    3. Substance dependence + non-SMI psychiatric disorder
    4. Substance abuse + non-SMI psychiatric symptoms
ii. Seriousness of baseline psychiatric disability
iii. Extent of substance use, and associated problems
iv. Specific psychiatric and substance diagnoses
v. Behavioral or medical risk/ involvement in other systems
    1. Homelessness
    2. Criminal behavior/violence
    3. Medical involvement (e.g., STD)
    4. Familial disruption/ child neglect or abuse
vi. Stage of treatment/stage of change
vii. Intensity of service utilization

Outcome must also be categorized as **long term**, defining the ultimate outcome of a continuing course of treatment with multiple interventions, versus **short term,** defining the expected outcome of a particular program or episode of care.

Finally, there are multiple dimensions of outcome, and the selection of which dimensions to measure depends on the variables listed above. These dimensions are enumerated in the following sections.

B. Improved Outcome of Psychiatric Illness

Improved psychiatric outcome is measured by reduction in symptomatology, increased functionality and stability, identification and attainment of recovery goals, reduction in high end service utilization, and improved quality of life.

For individuals with co-occurring psychiatric and substance disorders (ICOPSD), psychiatric outcomes are defined by the desired outcomes specified in the service planning guidelines for each psychiatric diagnosis.

C. Improved Outcome of Substance Disorder

1. Long-term outcome:

a. For individuals with substance dependence: sustained abstinence, increased functional capacity, and increased subjective experience serenity and recovery. (N.B. For ICOPSD in methadone maintenance treatment, desired outcomes regarding substance use, and continuation of methadone, are the same as for MMT in general.)

b. For individuals with serious mental illness and substance abuse: sustained non-harmful use (abstinence or occasional (less often than weekly) use of mild substances not to intoxication, and elimination of substance-related psychiatric symptom exacerbations.

c. For individuals with substance abuse and non-serious psychiatric symptoms: sustained non-harmful use defined by elimination of substance-related psychiatric symptoms or symptom exacerbations.

2. Short-term outcomes: dependent on specific program and stage of treatment.

a. Acute stabilization: safe detoxification or sobering up, plus safe stabilization of substance-induced or substance-exacerbated psychiatric symptoms or disorders, plus referral to continuing interventions for motivational enhancement and/or prolonged stabilization of each disorder.

b. Motivational enhancement: treatment engagement and progress through stages of change.
c. Active treatment for substance abuse: incremental small step changes in substance use patterns in order to achieve reduction in harm with minimum change. The pattern of use that is non-harmful is defined by successive trials in relation to the severity of psychiatric disability and symptoms.
d. Active treatment for substance dependence: commitment to abstinence and acquisition of skills and supports to maintain abstinence at the next level of care.
e. Relapse prevention: maintenance of abstinence or non-harmful use patterns through appropriate use of recovery supports and specific relapse prevention skills.
f. Rehabilitation and recovery: development of new skills and functional abilities to manage feelings and situations, to improve self-concept, serenity, and self-esteem, as stability continues.

C. Stage of Change

1. For individuals who are engaged in treatment for psychiatric disorders, but are pre-motivational regarding substance use: initial treatment outcome is defined by progress through stages of change or stages of treatment, as measured by Stages of Treatment Scale (McHugo et al) for SMI, Readiness to Change Scale, etc. Expected outcomes for individuals with SMI who are pre-motivational (in the "engagement" phase), based on the work of Drake et al, are that approximately 80% will move through one stage of treatment in six months.
2. For individuals who are not engaged in treatment for psychiatric disorders, and have co-occurring substance disorder: outcome can be defined by progress through stages of change regarding psychiatric treatment.

D. Reduction in Service Utilization

Interventions targeted to high service utilizers (e.g. intensive case management), often in managed care systems, will have the expected short-term outcome of reducing more intensive service utilization (e.g., hospitalization, detoxification) and increasing ambulatory contact. Evidence-based best practices targeting very high utilizers have achieved dramatic reductions within one year.

E. Harm Reduction and/or Improved Functioning and Stability

1. In the context of motivational enhancement interventions: individualized harm reduction goals can be identified as short-term outcome targets.
2. In the context of general functioning and involvement in other systems, harm reduction outcomes can include increased housing stability and reduced homelessness; reduction in arrest, incarceration, and/or criminal activity; reduction in abuse, neglect, and family disruption; increased medical stability and treatment adherence (e.g. for HIV regime); reduction in sexual risk behaviors; increased job stability and/or financial stability (e.g., reduction in level of payeeship supervision); increased socialization with healthy peers; and increased mental health treatment adherence and reduction of prescription drug misuse.
3. Achievement of harm reduction outcomes may often occur long before abstinence (or even full non-harmful use) is achieved.

III. Assessment, Differential Diagnoses, and Comorbid Conditions

Accurate diagnostic assessment for individuals with co-occurring disorders is complicated by the difficulty of distinguishing symptom patterns that result from primary psychiatric illness from symptom patterns that are caused or exacerbated by primary substance use disorders. In many individuals with co-morbidity, both psychiatric and substance disorders are simultaneously and interactively contributing to symptoms at the point of assessment, particularly if assessment occurs when the patient is acutely decompensated. Consequently, differential diagnostic assessment requires a careful, structured approach to assessment, often over a period of time, in order to best elucidate diagnosis accurately. This assessment approach will be described below..

A. Principles of Diagnostic Assessment

1. Welcoming expectation: Because of the high prevalence of comorbidity, routine assessment in all settings should be based on the assumption that any client is likely to have a comorbid condition. Direct communication to the client that such a presentation is both welcome and expectable will facilitate honest disclosure.
2. Accessibility and Flexibility: Assessment begins at the point of clinical contact, regardless of the client's clinical presentation. Initiation of assessment should not be made conditional on arbitrary criteria such as length of abstinence, non-intoxicated alcohol level, negative drug screen, absence of psychiatric medication, and so on. Although in some individuals with co-occurring disorder, establishing an accurate diagnosis of one disorder requires the other disorder to be at baseline, in most cases diagnosis can be reasonably established by

history (see below). Moreover, treatment must usually be initiated when neither disorder is at baseline; consequently, initial diagnoses are often presumptive, and the initial goal of assessment is to engage the individual in an ongoing process of continual reassessment as treatment progresses, during which diagnoses may be continually revised as new data emerge.

3. Screening and Detection:
    a. Screening tools in the mental health setting for substance disorders may include the following: Checklists of substances, including amounts and patterns of use for each (include inquiry regarding over the counter preparations, caffeine, nicotine, and gambling); screening tools validated for use in people with mental illness (e.g., CAGE, MAST/DAST, DALI, RAFFT for adolescents – see Appendix A.); and selective use of urine screens, particularly for adolescents and for unreliable historians with puzzling presentations.
    b. For mental health screening in substance treatment settings, the use of symptom checklists (e.g., Brief Psychiatric Symptom Inventory, MINI, Project Return Mental Health Screening Form III – See Appendix B.) can be helpful to facilitate referral for a more comprehensive mental health diagnostic evaluation.
4. Collateral Contact: screening AND assessment should routinely incorporate obtaining permission to contact – and contacting- all available collaterals, including family, friends, case manager, probation officer, protective service worker, and other treaters, as well as obtaining records of previous treatment episodes.
5. Diagnostic Determination:
    a. Diagnosis of either mental illness or substance use disorder can rarely be established only by assessment of current substance use, mental health symptoms, or mental status exam. In most cases, diagnosis is more reliably established by obtaining a good history that is integrated, longitudinal, and strength-based.
    b. Diagnosis of substance use disorders involves review of past and current patterns of substance use, and observing whether those patterns meet criteria for substance dependence or substance abuse.
    c. Diagnosis of substance dependence is frequently based on evidence of lack of control of substance use in the face of clear harmful consequences, whether or not tolerance and withdrawal symptoms are present. Once substance dependence has been identified in the

past, that diagnosis persists, even if the person currently exhibits reduced use or abstinence.

d. Diagnosis of substance abuse requires exclusion of substance dependence, and identifying a pattern of harmful use in relation to the individual's own context. For a person with a mental illness, any controlled use of substances that interferes with treatment or outcome can be defined as abuse, and the extent of use that would be considered problematic is inversely related to the severity of the psychiatric disorder or disability. For individuals with severe mental illness who are disabled at baseline, any persistent use of substances is likely to be considered abuse, even though harmful effects may not be apparent on each occasion.

e. Diagnosis of non- substance related psychiatric disorders similarly requires careful review of past and current patterns of mental health symptoms, in relation to presence or absence of appropriate medication and periods of substance abstinence or reduced use. Presence of symptoms meeting criteria for DSM IV psychiatric disorder during periods of abstinence or reduced use that exceed the resolution period for those symptoms based on the type and extent of substance use (see SUPS Table in Appendix C) meet presumptive criteria for mental illness.

f. All diagnoses should be initially considered to be presumptive, and subject to continual reevaluation and revision during the course of continuing treatment.

g. Whenever a psychiatric disorder and a substance disorder co-exist, even if the psychiatric disorder is substance-induced, both disorders should be considered primary, in the sense that each disorder requires appropriately intensive primary diagnosis-specific treatment simultaneously.

6. SMI Determination: SMI determination requires establishing (using the assessment methodology in the previous paragraph) a presumptive (NOT necessarily definitive) diagnosis of an SMI eligible psychiatric disorder, persistence of that disorder for six months, and functional incapacity as measured by ALFA criteria in accordance with DBHS Policy 1.14, utilizing the SUPS Table (Appendix C) to assess the resolution period after which substance-related contribution to symptomatology and functional incapacity are likely to be significantly reduced or eliminated.

B. Differential Diagnoses

1. Substance Disorder: Distinguish substance use, substance abuse, and substance dependence. Distinguish types and categories of substances.

2. Psychiatric Disorder: Distinguish substance induced psychiatric disorder, non-SMI psychiatric disorder, SMI psychiatric disorder.

3. Co-occurring Disorder Subtype: SMI + substance dependence (high-high); SMI + substance abuse (high-low); non-SMI/ substance-induced disorder + substance dependence/severe abuse (low-high); non-SMI/psychiatric symptoms + substance abuse (low-low).

C. Comorbid Conditions

1. Trauma related disorders: Individuals with co-occurring psychiatric disorders (SMI) and substance disorders have a high prevalence of trauma histories and trauma related symptoms, women (85%) more so than men (50%).
2. Cognitive disorders: Individuals with co-occurring disorders have a high risk of comorbid cognitive impairment, with causes ranging from congenital conditions (ADD, learning disabilities) to sequela of substance use, medical conditions, and/or head injuries. Assessment of cognitive impairment is important in modifying treatment in accordance with the individual's ability to learn most effectively.
3. Personality traits and disorders: Individuals with co-occurring axis I disorders will frequently exhibit symptoms and behavior characteristic of axis II disorders. At times, these dysfunctional personality traits will resolve as recovery progresses; at times they represent enduring personality disorders.
4. Medical conditions: Individuals with co-occurring disorders are a high risk population for multiple medical conditions, most notably sexually transmitted diseases.

IV. Intervention Strategies

There is no one single correct intervention for individuals with co-occurring disorders. Intervention strategies must be appropriately matched to individualized clinical assessment based on the parameters listed below. Diagnosis specific interventions for psychiatric and substance disorder are addressed in the practice guidelines for each separate disorder; this section will cover only those issues that relate to individuals with co-occurring disorders specifically. See Appendix D for a template for matching interventions according to subtype of dual disorder and stage of change/phase of recovery.

A. Continuity of Care Interventions: Research-based principles (Drake et al, 1993; Minkoff et al, 1998) emphasize the importance of empathic, hopeful,

continuing treatment relationships, provided by an individual clinician, team of clinicians (Continuous Treatment Team – CTT; Integrated ACT), or community of recovering peers and clinicians (Modified Therapeutic Community [Sachs; DeLeon]; Dual Recovery Clubhouse), in which integrated treatment and coordination of care take place across multiple treatment episodes. Integrated treatment implies that the primary treatment relationship integrates mental health and substance interventions at any point in time and over time into a person-centered whole.

B. Episodes of Care: Both psychiatric and substance disorders are chronic relapsing conditions, and individuals may be appropriately served by a variety of episodic interventions at different points in time. Episodes of care may occur in acute, subacute, or long-term settings, in either mental health or substance treatment settings. (See Programs in Section V (C).) Ideally, there is a continuous interaction between "continuity interventions", which are unconditional and flexible, with various episodes of treatment which have time-limits and expectations which affect entry and discharge.

C. Subtype of Co-occurring Disorder: Subtype of co-occurring disorder affects locus of responsibility for client. Individuals who are seriously mentally ill (SMI) are eligible for types of services (including continuing case management) that individuals with non-SMI symptoms or disorders cannot get. Non-SMI individuals require specific mechanisms for providing such continuity of care or case management through other means. Similarly, individuals with substance dependence are more likely to be appropriate for involvement in addiction episodes of care in the addiction system than are individuals with only substance abuse.

D. Diagnosis-Specific Treatment:
    1. Integrated Dual Primary Treatment: When mental illness and substance disorder co-exist, both disorders are considered primary, and appropriately intensive simultaneous diagnosis- specific treatment for each disorder is required. <u>Integrated dual primary treatment is NOT a new intervention. Rather, it involves a variety of methods by which diagnosis-specific, evidence-based strategies for each type of disorder are appropriately combined and coordinated in a single setting and in an integrated treatment relationship, and in which the interventions for each disorder are appropriately modified (if necessary) to address treatment impediments resulting from the other disorder.</u>
    2. Psychiatric Disorder: Treatment for known diagnosed mental illness must be initiated and maintained, including maintaining non-addictive medication, even for individuals who may be continuing to use substances. In addition, the best available psychiatric medication regime for each disorder may promote better outcomes for both disorders. Non-psychopharmacologic treatment regimes (e.g., dialectic behavioral therapy for borderline personality disorder) may be appropriately utilized to develop cognitive-behavioral skills to manage the mental illness, while applying similar skills to managing

substance use, and integrating direct substance disorder treatment interventions as well.

3. Substance Disorder:
    a. Substance abuse treatment: individual and group interventions to help individuals make, and implement, better choices regarding substance use in relation to their mental illnesses. Outcomes focus on limitation of use to achieve reduction in harmful outcome. For individuals with severe mental illness and baseline disability, abstinence outcomes are recommended, even though use can be controlled.
    b. Substance dependence treatment (addiction treatment) for individuals with co-occurring disorders is fundamentally similar to addiction treatment for anyone, with abstinence as a goal, and with the need to develop specific skills for attaining and maintaining abstinence, including use of generic recovery meetings (AA) and dual recovery programs (DRA, DTR). Individuals with serious psychiatric impairment often require more addiction treatment in smaller increments with more support over a longer period to attain recovery skills. Treatment interventions must be simpler, more concrete, with more role rehearsal, to meet the needs of seriously psychiatrically impaired individuals, and require maintaining continuing mental health supports and integrated treatment relationships while the learning process takes place.

E. Phase of Recovery/Stage of Change/Stage of Treatment: Four phases of recovery (Minkoff, 1989): acute stabilization; motivational enhancement/engagement; prolonged stabilization (active treatment/relapse prevention); rehabilitation and recovery; five stages of change (Prochaska & DiClemente, 1992): pre-contemplation, contemplation, preparation, action, maintenance; four stages of treatment for seriously mentally ill individuals with substance disorders (Osher & Kofoed, 1989): engagement, persuasion, active treatment, and relapse prevention. Research clearly states that effective interventions must be stage specific. This implies that the strategy for individuals who are pre-contemplative is to apply motivational enhancement interventions (individual and/or group) to help those individuals to be contemplators, and so on. Existing motivational enhancement strategies (cf. Miller and Rollnick, 1991; TIP #35, 1999) have been successfully adapted to individuals with serious mental illness (Carey, 1996). Stage-specific group interventions have demonstrated effectiveness.

F. Extent of Impairment:

1. Assess strengths and disabilities to determine extent to which individuals require care and support unconditionally.
2. At each point in time during the course of treatment, whether in the context of a continuing treatment relationship, or during an episode of care, balance case management and care with detachment, empowerment, expectation, and confrontation for each individual.
3. More seriously impaired individuals at baseline (e.g., individuals with serious mental illnesses) are likely to require more extensive case management, support, and structure (unconditionally) to accommodate their psychiatric disabilities.
4. Methods for providing contingent learning opportunities within such structure include tightly managed payeeships, residential and day programs with a variety of contingent learning opportunities, etc. Contingencies and expectations must be matched to the individual's stage of change and capacity for learning, and are ideally developed maximizing consumer choice and participation.
5. For individuals requiring episodes of addiction treatment, requirement for psychiatric enhancement or modification of addiction treatment settings is proportional to the extent of psychiatric symptomatology or disability. Thus, different categories of addiction program (Dual Diagnosis Enhanced – DDE; Dual Diagnosis Capable – DDC) are required for different populations. (See Section V(B) for more description of program categories.)

G. External Contingencies:
1. Involvement of the criminal justice system or the protective service system may create treatment leverage that enhances motivation and treatment participation. Such interventions often require close collaboration between primary mental health and addiction clinicians with protective service workers and probation officers.
2. External contingencies may also be present through the involvement of natural caregivers (e.g., families) to develop collaborative strategies of contingency management and intervention.
3. Contingencies may emerge through participation in programmatic interventions within the treatment system: payeeships, abstinence-expected housing, etc. Careful integration of contingency management strategies into ongoing treatment planning can substantially enhance outcome, provided the contingencies are tightly managed, non-punitive, and organized to promote continuous learning.

H. Level of Care:
1. Almost any combination of stage-specific, diagnosis-specific interventions can occur at almost any level of care. Level of care determination involves multidimensional assessment, guided by instruments such as the ASAM criteria (PPC 2R, 2001) or the LOCUS (Version 2.001).

2. ASAM dimensions of assessment involve measures of detoxification risk, biomedical complication, emotional/behavioral complication, motivation, relapse potential, and recovery environment.
3. LOCUS dimensions of assessment include acuity/dangerousness, functional capacity, comorbidity, motivation/adherence; recovery support; and treatment response history.

V. Recommended Practice Standards and Programs

A. Practice Standards

1. Welcoming expectation: Individuals with comorbidity are an expectation in every treatment setting, and should be engaged in an empathic, hopeful, welcoming manner in any treatment contact.
2. Access to assessment: Access to assessment or to any service should not require consumers to self-define as mental health OR substance disordered before arrival. Assessment should routinely expect that all consumers may have comorbid disorders, and that the assessment process may need to be ongoing in order to accurately determine what disorders are present, and what interventions are required. Arbitrary barriers to mental health assessment based on alcohol level or length of sobriety should be eliminated. Similarly, no one should be denied access to substance disorder assessment or treatment due to the presence of a comorbid psychiatric disorder and/or the presence of a regime of non-addictive psychotropic medication.
3. Access to continuing relationships: For individuals with more severe comorbid conditions, empathic, hopeful, continuous treatment relationships must be initiated and maintained even when the individual does not follow treatment recommendations.
4. Balance case management and care with expectation, empowerment, and empathic confrontation: Within a continuing relationship or an episode of care, consumers are provided assistance with those things that they cannot do for themselves by virtue of acute impairment or persistent disability, while being empowered to take responsibility for decisions and choices they need to make for themselves, and allowed to be empathically confronted with the negative consequences of poor decisions.
5. Integrated dual primary treatment: Each disorder receives appropriate diagnosis-specific and stage-specific treatment, regardless of the status of the comorbid condition. Each disorder must not be undertreated because the other disorder is present; in fact, individuals often require enhanced treatment for either disorder because of the presence of comorbidity. For individuals with serious mental illness, for example, active substance use disorder may be an indication for using more effective psychotropic medication for the primary mental illness. Similarly, individuals with serious mental illness may require more addiction treatment than individuals with addiction only, in the sense

that they need more practice, rehearsal, and repetition, in smaller increments, with more structure and support, to learn recovery skills.

6. Stage-wise treatment: Interventions –and expected outcomes- need to be matched to stage of change.
    i. Acute stabilization: Detoxification or safe sobering up; initial stabilization of acute psychiatric symptoms.
    ii. Motivational Enhancement: Individual motivational strategies (Miller & Rollnick; Carey) and pre-motivational or persuasion groups (Sciacca, Noordsy). In the latter, group process facilitates discussion of substance use decisions for group members who are likely to be actively using and have made no commitment to change.
    iii. Active Treatment: Individual and group treatment interventions for substance use disorders in individuals with psychiatric disorders and disabilities often require focus on specific substance reduction or elimination skills, including participation in self-help recovery programs (particularly for those with addiction), but with modification of skills training to accommodate disability-impaired learning capacities. These interventions may require smaller groups, with more specific role-playing and behavioral rehearsal of more basic skills. (Noordsy, Mueser, Bellack, Shaner)
    iv. Relapse Prevention: May require specific skills training on participation in recovery programs, as well as access to programs like Dual Recovery Anonymous (Hamilton) or Double Trouble in Recovery (Vogel).
7. Early access to rehabilitation: Disabled individuals who request assistance with housing, jobs, socialization, and meaningful activity are provided access to that assistance even if they are not initially adherent to mental health or substance disorder treatment recommendations.
8. Coordination and collaboration: Both ongoing and episodic interventions require consistent collaboration and coordination between all treaters, family caregivers, and external systems. Collaboration with families should be considered an expectation for all individuals at all stages of change, as families may provide significant assistance in developing strategies for motivational enhancement and contingent learning, in identifying specific skills or techniques required for modification of substance using behavior, and in actively supporting participation in recovery-based programming to promote relapse prevention.

B. Program Categories (ASAM PPC2R; Minkoff)

Within any system of care, available programmatic interventions can be categorized according to dual diagnosis capability. The expectation is that all programs in either system evolve to become at least dual diagnosis

capable (DDC-CD; DDC-MH), and a subgroup of services is designed to be dual diagnosis enhanced (DDE-CD; DDE-MH).

1. DDC-CD: Welcomes individuals with co-occurring disorders whose conditions are sufficiently stable so that neither symptoms nor disability significantly interfere with standard treatment. Makes provision for comorbidity in program mission, screening, assessment, treatment planning, psychopharmacology policies, program content, discharge planning, and staff competency and training.
2. DDC-MH: Welcomes individuals with active substance use disorders for MH treatment. Makes provisions for comorbidity as above. Incorporates integrated continuity of case management and/or stage-specific programming, depending on type of program.
3. DDE-CD: DDC program enhanced to accommodate individuals with subacute symptomatology or moderate disability. Enhanced mental health staffing and programming, increased levels of staffing, staff competency, and supervision. Increased coordination with continuing mental health or integrated treatment settings.
4. DDE-MH: MH program with increased substance related staffing skill or programmatic design: e.g., dual diagnosis inpatient unit, providing addiction programming in a psychiatrically managed setting; intensive dual diagnosis case management teams (CTT), providing pre-motivational engagement and stage-specific treatment for the most impaired and disengaged individuals with active substance disorders; comprehensive housing or day programs, providing multiple types of stage-specific treatment interventions and substance-related expectations.

C. Program Models (**This section needs to be modified according to program models that are actually available in Arizona.)**

1. Continuous Integrated Case Management: Range from high intensity to low intensity, and DDC or DDE. High intensity DDE programs include Continuous Treatment Teams (CTT) (Drake and Mueser), or integrated ACT teams. Moderate intensity programs include DDC or DDE case management teams (ICM, SCM). Low intensity intervention may be provided by individual outpatient clinicians (plus psychopharmacologists) in outpatient clinic settings.
2. Continuous Recovery Support: Dual Recovery Clubhouse programs (DDE) or Clubhouse programs with dual recovery supports or tracks (DDC); Dual Recovery self-help programs.
3. Emergency Triage/ Crisis Intervention (DDC): Welcomes any type of mental health and/or substance presentation, provides initial triage, level of care assessment, and crisis intervention and/or referral
4. Crisis Stabilization Beds (DDC): Hospital diversion in staffed setting for individuals with psychiatric presentations who may be actively using substances, but do not require medically monitored detox.
5. Psychiatric Inpatient Unit or Partial Hospital (DDC or DDE): The former does routine assessment, engagement, motivational

enhancement, and stage-specific groups; the latter provides more sophisticated assessment plus addiction treatment in a psychiatrically managed setting. DDE programs have also been designed and implemented in state hospitals for individuals in long-term care.

6. Detoxification programs (DDC or DDE). Specialized psychiatrically enhanced detox (Wilens) can provide supervised detoxification for individuals who may have acute psychiatric exacerbations (e.g., suicidality, aggressive impulsivity, psychosis) but who can be safe in an unlocked staffed setting.
7. Psychiatric Day Treatment (DDC or DDE): Intermediate to long-term programs for psychiatric support that provide varying degrees of stage-specific programming and integrated case management. DDE programs have more sophisticated staff, more linkages with substance programming, and a full range of stage-specific groups.
8. Addiction IOP, Partial, Residential (DDC or DDE): Episodes of abstinence-oriented <u>active</u> addiction treatment in settings with varying degrees of psychiatric capability. Programs can be very long term (years), such as Modified Therapeutic Community, or short term (one to two weeks, up to 60 days)
9. Psychiatric Housing Programs: Provide housing supports for individuals with psychiatric disabilities. Programs need to be matched according to stage of change;

    a. Abstinence-expected ("dry") housing: This model is most appropriate for individuals with comorbid substance disorders who choose abstinence, and who want to live in a sober group setting to support their achievement of abstinence. Such models may range from typical staffed group homes to supported independent group sober living. In all these settings, any substance use is a program violation, but consequences are usually focused and temporary, rather than "one strike and you're out".

    b. Abstinence-encouraged ("damp") housing. This model is most appropriate for individuals who recognize their need to limit use and are willing to live in supported setting where uncontrolled use by themselves and others is actively discouraged. However, they are not ready or willing to be abstinent. Interventions focus on dangerous behavior, rather than substance use per se. Motivational enhancement interventions are usually built in to program design.

    c. Consumer-choice ("wet") housing. This model has had demonstrated effectiveness in preventing homelessness among individuals with persistent homeless status and serious psychiatric disability (Tsemberis, 2000: "Pathways to Housing Program"). The usual approach is to provide independent supported housing with case management (or ACT) wrap-around, focused on housing retention. The consumer can use substances as he chooses (though recommended otherwise) except to the extent that use

related behavior specifically interferes with housing retention. Pre-motivational and motivational interventions are incorporated into the overall treatment approach.

VI. Psychopharmacology Practice Guidelines (Minkoff, et al, 1998)

A. Assessment

1. Initial psychopharmacologic assessment in mental health settings should not require consumers to be abstinent.
2. Initial psychopharmacologic evaluation in substance disorder treatment should occur as early in treatment as possible, and incorporate capacity to maintain existing non-addictive psychotropic medications during detoxification and early recovery.
3. Diagnostic assessment of individuals with co-occurring disorders is based ideally on obtaining an integrated, longitudinal, strength-based history, which incorporates a careful chronological description of the individual's functioning, including emphasis on onset, interactions, effects of treatment, and contributions to stability and relapse of both disorders at each point in time. Particular focus is on assessing either disorder during periods of time when the other type of disorder is relatively stable. Obtaining information from family members, previous treaters, and collateral caregivers is extremely important.
4. Diagnostic and treatment decisions regarding psychiatric illness are best made when the comorbid substance disorder is stabilized. Nonetheless, thorough assessment (as described above) usually provides reliable indications for initial diagnosis and psychopharmacologic treatment, even for individuals who are actively using. This is particularly true for individuals with SMI.
5. Diagnostic and treatment decisions regarding substance disorder (including psychopharmacologic decisions) are best made when the comorbid psychiatric disorder is at baseline. Nonetheless, thorough assessment usually provides reliable information about the course and severity of the substance disorder, even for individuals whose mental illness is destabilized.

B. General Principles of Psychopharmacologic Treatment

1. Psychopharmacology for people with co-occurring disorders is not an absolute science. It is best performed in the context of an ongoing, empathic, clinical relationship that emphasizes continuous re-evaluation of both diagnosis and medication, and artful utilization of medication strategies to promote better outcome of both disorders.
2. Psychopharmacologic providers need to have ready access to peer review or consultation regarding difficult patients.
3. Some initial evidence of improvements in addictive disorders has been associated with several classes of psychiatric medications (e.g., SSRIs, bupropion, atypical antipsychotics – especially, clozapine – and others). The prescriber may want to consider the potential impact on

the substance use disorder when choosing a medication for the psychiatric disorder.

4. In general, psychopharmacologic interventions are designed to maximize outcome of two primary disorders, as follows:
    a. For diagnosed psychiatric illness, the individual receives the most clinically effective psychopharmacologic strategy available, regardless of the status of the comorbid substance disorder.
    b. For diagnosed substance disorder, appropriate psychopharmacologic strategies (e.g., disulfiram, naltrexone, methadone/buprenorphine/LAAM) may be used as ancillary treatments to support a comprehensive program of recovery, regardless of the presence of a comorbid psychiatric disorder (although taking into account the individual's cognitive capacity and disability).

6. In general, psychopharmacologic providers will prioritize the following tasks, in order:
    a. Establish medical and psychiatric safety in acute situations

    i. In <u>acutely dangerous</u> behavioral situations, utilize antipsychotics, benzodiazepines, and other sedatives, as necessary, in order to establish rapid behavioral control.
    ii. In <u>acute</u> withdrawal situations requiring medical detoxification, use detoxification medications for addicted psychiatric patients according to the same protocols as used for patients with addiction only.

    b. Maintain stabilization of severe and/or established psychiatric illness.

    i. Provision of necessary non-addictive medication for treatment of psychotic illness and other known serious mental illness must be initiated or maintained regardless of continuing substance use. Ongoing substance use is not a contraindication to use of clozapine, olanzapine, risperidone, quetiapine, or other atypical neuroleptics. Improving psychotic or negative symptoms may promote substance recovery.
    ii. In patients with active substance dependence, non-addictive medication for established less serious disorders (e.g., panic disorder) may be maintained, provided reasonable historical evidence for the value of the medicine is present.

    c. Use medication strategies to promote or establish sobriety.

i. Utilizing medication (e.g., disulfiram, naltrexone) to help treat addiction should always be presented as an ancillary tool to complement a full recovery program. Communicate clearly that medication will not eliminate the need for the patient to actively work on developing recovery skills.

iii. Psychotropic medications for comorbid psychiatric disorders should be clearly directed to the treatment of known or probable psychiatric disorders – not to medicate normally occurring and expectable painful feelings.

iv. Addicts in early recovery have a great deal of difficulty regulating medication; fixed dose regimes, not prn's, are recommended, except for regulation of psychotic symptoms.

v. In clinical situations where the psychiatric diagnosis and/or the severity of the substance disorder may be unclear, psychotropic medication may be used to treat presumptive diagnoses as part of a strategy to facilitate engagement in treatment and the creation of contingency contracts to promote abstinence.

d. Diagnose and treat less serious psychiatric disorders (e.g., affective, anxiety, trauma-related, attentional, and/or personality disorders that are not serious or disabling) that may emerge once sobriety is established.

i. Once a disorder and an efficacious treatment regime for that disorder have been established, it is recommended to maintain that treatment regime even if substance use recurs.

iii. In patients with **active** substance **dependence,** it is not recommended to initiate medication for newly diagnosed non-serious disorders while patients are actively using; it is usually impossible to make an accurate diagnosis and effectively monitor treatment.

iv. In patients with substance dependence in very early recovery, however, non-addictive medication for treatment of presumptive primary non-serious psychiatric disorders may be initiated, if there is reasonable indication that such a disorder might be present.

v. It is **not recommended** to establish arbitrary sobriety time periods for initiation of medication. At times, it may be appropriate to initiate psychotropic medication for non-psychotic disorders in the latter stages of detoxification; at other times, it may be appropriate to wait a few weeks, or even longer. With the emergence of newer medications (e.g., SSRI's) with more benign side effect profiles, there is little evidence that prescription of these medications inhibits

recovery from substance dependence, and some evidence that such medication may in fact promote successful abstinence.

vi. Prescribers need to carefully consider the risks of prescribing potentially addictive medications (Schedule II-IV substances; non-specific sedatives, such as antihistaminics, etc.) beyond the detoxification period. Continuing prescription of these medications should generally be avoided for patients with known substance dependence (active or remitted). On the other hand, they should not be withheld for selected patients with well-established abstinence who demonstrate specific beneficial responses to them without signs of misuse, merely because of a history of addiction. However, consideration of continuing prescription of potentially addictive medications for individuals with diagnosed substance dependence is an indication for both (a) careful discussion of risks and benefits with the patient (and, where indicated, the family) and (b) documentation of expert consultation or peer review with more experienced addiction prescribers if possible.

vii. For patients with histories of addiction who present for treatment on already established regimes of addictive medication (e.g., benzodiazepines), prescribers should establish an initial treatment contract that connects continued prescription with continued abstinence. In the event of relapse, the prescriber can work with the patient over time to titrate gradual reduction of the benzodiazepine with continued opportunities to establish and maintain abstinence. If it becomes clear that abstinence cannot be maintained, then taper and discontinuation of the benzodiazepines is indicated. A recommended tapering strategy is to switch the patient to equivalent dosing of Phenobarbital, add carbamazepine at a therapeutic dose (valproate or gabapentin may also be used), and then taper the Phenobarbital over 7-10 days.

D. Diagnosis-Specific Recommendations

1. **Schizophrenic Disorders:** Individuals with active comorbid substance disorder may benefit from addition of atypical neuroleptics. Initial studies indicate that clozapine, in particular, may have direct effect on reduction of substance abuse, in addition to improvement of substance reduction skills through reduction in positive and negative symptoms.
2. **Bipolar Disorders:** Many individuals with co-occurring substance use disorder appear to respond preferentially to second and third generation mood stabilizers, such as valproate and lamotrigine. This is likely to be more due to better efficacy with rapid cycling and atypical mood disorders, as well as broader efficacy with regard to impulsivity, anger, PTSD, and anxiety symptoms, rather than due to a direct effect on substance disorder. Addition of second line mood stabilizers such

as gabapentin and topiramate may also be useful. A significant population of individuals, however, will still respond best to lithium.

3. **Depressive Disorders:** No particular category of antidepressant is specifically recommended or contraindicated, although tricyclics are more difficult to use and more sedating. There is data that serotoninergic medication may be helpful in certain addicted individuals, particularly those with early-onset alcoholism. Venlafaxine and nefazodone may have more anti-anxiety benefit than conventional SSRIs.
4. **Anxiety Disorders:** Recommendations on how to use benzodiazepines for individuals with addiction have been discussed in the previous section. Medication strategies for panic disorder are otherwise no different than for individuals without substance use disorders. For generalized anxiety, recommendations may include clonidine or guanfacine; venlafaxine, nefazodone, SSRIs, etc.; gabapentin, valproate, topiramate (PTSD symptoms especially); atypical neuroleptics. Buspirone can be effective, but it takes longer to work (months) in higher doses (over 60 mg usually) in individuals with histories of addiction and/or benzodiazepine use.
5. **Attentional Disorders:** Bupropion is often recommended as the first medication in early sobriety, proceeding to SSRIs and/or tricyclics. Ordinarily, sobriety should be well-established before initiation of stimulants. Data in both adolescents and adults clearly support, however, the effectiveness of stimulants, when taken properly in individuals with clearly diagnosed ADHD, in improving outcome for both ADHD and substance disorder.
6. **Addictive Disorders:** Although medication strategies for treatment of addiction, including opiate maintenance therapy, have not been extensively studied in mentally ill populations, there is no evidence to indicate they are differentially effective in those populations compared to non-mentally ill populations. A few studies have demonstrated effectiveness of tightly monitored disulfiram in severely mentally ill alcoholics, when combined with other substance treatments. Naltrexone, acamprosate, etc. are all apparently effective in mentally ill populations <u>when otherwise indicated.</u> Use of these interventions should be restricted to motivated individuals participating in abstinence-oriented treatment, as an ancillary tool to support recovery. Within such populations, there is not yet clear data to determine who should be treated with psychopharmacologic interventions, and at what point in the treatment process.